MEDICAL EQUIPMENT REQUEST EVALUATION FORM NON-WHEELCHAIR
(Fee-for-Service (FFS) Program Only – Not to be Used for Managed Care)

Pursuant to He-W 571.05(e), requests for all standers, gait trainers, and bath and toileting items shall (in addition to Form 272D) include a completed Form 272EQ, "Medical Equipment Request Evaluation Form Non-Wheelchair."

This evaluation must be completed by a New Hampshire licensed physician, APRN, or ordering occupational therapist or physical therapist specializing in rehabilitation medicine. Evaluator must have an understanding of the recipient's condition for which the equipment is being requested and broad knowledge of the various rehabilitation equipment available in the market today that may benefit the recipient. **NOTE:** Requests for wheelchair equipment should not be made on this form. Wheelchair equipment requests should be made using, "Form 272M - Mobility Evaluation."

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT INFORMATION

RECIPIENT NAME: _____ DATE OF BIRTH:_____

RECEPIENT HEIGHT: _____ RECIPIENT WEIGHT: _____

RECIPIENT MEDICAID ID #: _____ DIAGNOSIS CODES: _____

ALTERNATE INSURANCE: NAME OF PLAN _____

PROVIDER/EVALUATOR INFORMATION

DATE OF EVALUATION: _____ CONTACT PERSON: _____

TELEPHONE #: _____ FAX #: _____

EVALUATOR NAME:_____ EVALUATOR MEDICAID ID #:_____

PERFORMING FACILITY: _____ PERFORMING FACILITY MEDICAID ID #:_____

DIAGNOSIS (written, not ICD-CM) PRIMARY ___ _____

SECONDARY: ____ _____

EQUIPMENT REQUESTED:

☐ Stander ☐ Gait Trainer ☐ Positioning Chair ☐ Bath Equipment ☐ Other (non-wheelchair only) _____

Please provide medical justification for providing the equipment requested above:

Is the requested equipment replacing a piece of equipment that the recipient currently has? ☐ Yes ☐ No

Does the requested equipment duplicate a piece of equipment that the recipient currently has? ☐ Yes ☐ No

If YES to either of the above, please answer the following:
Model and make of current equipment:_____
_____

Age and condition of current equipment: _____

Reason for replacing or duplicating: _____

Where is the primary location of use? ☐ Home ☐ School ☐ Other _____

Given the recipient's age and expected rate of growth, what is the anticipated number of years the recommended equipment is expected to be functional? _____

With respect to the growth potential of the recommended equipment, what is the maximum height and weight capacity?

Height: _____ Weight: _____

How frequently is the equipment expected to be utilized each day or week, and for how long each day or week? _____

Has the recipient completed a trial period of at least two (2) weeks with the recommended equipment? ☐ Yes ☐ No

Is similar equipment currently available or being utilized by the recipient at school, home, or other site? ☐ Yes ☐ No

If **YES**, please explain: _____

_____

Please identify any plans to obtain funding from any other sources (e.g., private insurance, Grants, "Medicaid to School"):

_____

_____

What other, less costly equipment alternatives have been considered (provide specific makes and models)? Why were they not chosen? _____

_____

Please explain why no other alternative equipment options were considered, if applicable: _____

_____

Please check **ALL** that apply regarding the recommended equipment:

- ☐ Recipient's home has sufficient space to utilize and store the equipment.
- ☐ Potential growth of recipient has been taken into consideration in selecting the size of equipment, which should provide at least 5 years of use.
- ☐ Recipient or recipient's caregiver has demonstrated proficiency in the safe operation of the equipment.
- ☐ Less costly models have been ruled out as inappropriate.

Additional comments:

_____

_____

_____

_____ _____

Signature of NH licensed OT/PT or physician or APRN completing the evaluation Date

INDIVIDUALS PRESENT DURING EVALUATION:

1) _____ Representing/Relationship to recipient: _____

2) _____ Representing/Relationship to recipient: _____

3) _____ Representing/Relationship to recipient: _____

RECIPIENT, PARENT OR LEGAL GUARDIAN (please check the statement that applies)

☐ I accept the recommendations for the make, model and options of the equipment being requested and acknowledge that the safe operation and benefits of the equipment's options and features have been fully explained to me. I have no questions or concerns regarding the recommendations made.

☐ I do not agree with all of the recommendations and I request changes based on the following:

_____

_____

_____

_____ _____ _____

Signature of Recipient/Parent/Legal Guardian | Relationship | Date

DISPENSING PROVIDER INFORMATION

Please check the statement that applies. If a statement does not apply, please provide your response in the comments section below:

☐ I concur with the recommendations made, and I am unaware of any other **less costly** equipment models or alternatives in the market at this time that would meet this recipient's needs.

☐ To the best of my knowledge, the recipient ☐ does ☐ does not expect to receive a similar piece of equipment from any other funding source.

COMMENTS: _____

_____

_____

_____ _____

Signature of DME Vendor | Date

_____ _____

Printed Name of DME Vendor | Name of agency

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL

129 Pleasant St ■Concord, NH 03301 ■FAX: (603) 271-8194

MOBILITY EVALUATION FORM:
FORM 272EQ FFS MEDICAL EQUIPMENT REQUEST EVALUATION FORM NON-WHEELCHAIR

The only change made to this form is to cite the rule regarding its use. This form must be filled out pursuant to He-W 571.05(e): Requests for all standers, gait trainers, and bath and toileting items shall also include a completed Form 272EQ, Medical Equipment Request Evaluation Form, Non-Wheelchair.

Please note that before this form is filled out, **it is your responsibility to verify eligibility** of the recipient for the Fee-for-Service (FFS) program. That can be done by calling the number on the back of the recipient's Medicaid card; calling Conduent at 886-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

The first two sections are the Recipient Information and Provider Information and should be filled out accordingly. Fill in all sections of the form by printing your answer to each question. **This form should be signed by the wheelchair vendor, the physician and a therapist.**

Attach this document, the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request to the DME Service Authorization Request. Fax all documentation to 603-271-8194. You will receive a fax from the state with the authorization information or a request for more information.